COMMONWEALTH OF VIRGINIA
Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
ACTING STATE HEALTH COMMISSIONER

OFFICE OF ADJUDICATION

DOUGLAS R. HARRIS, J.D.

RECOMMENDATION TO THE STATE HEALTH COMMISSIONER
REGARDING CERTIFICATE OF PUBLIC NEED (COPN)
REQUEST NUMBER VA-6592
DANVILLE REGIONAL MEDICAL CENTER
ADDITION OF THREE OPERATING ROOMS IN PLANNING DISTRICT 12

A. FINDINGS OF FACT

1. On July 27, 2001, Danville Regional Medical Center (DRMC), a non-stock, not-for-profit Virginia corporation owned by Danville Regional Health System, a non-stock, not-for-profit Virginia corporation, applied for a certificate of public need (COPN). DRMC's application seeks authorization for a proposed project to (i) carry out a capital expenditure exceeding five million dollars and (ii) add three operating rooms (ORs) and replacement of a single existing OR.

2. The two aspects of the project are closely intertwined insofar as the application envisions the construction of a new dining facility, which will allow conversion and renovation of the existing dining space into the proposed ORs and surgical support space. The total capital cost of the overall project is $5,954,100, including an allowance for contingencies of $275,730.

3. At the informal fact finding conference (IFFC), noted below, held to discuss this application, DRMC's vice-president for planning and marketing noted that the total cost of the project, excepting the cost of the three additional operating rooms "would be well under five million dollars." After conducting additional review following the IFFC, the applicant identified the cost of the construction relating only to the proposed ORs to total $3,959,200.

4. DRMC is located in the City of Danville, in Planning District (PD) 12, Health Planning Region (HPR) III. The Health Planning Agency of Southwest Virginia (HPASWV) serves HPR III by reviewing "projects," as defined in Section 32.1-102.1 of the Virginia Code, proposed for location within the boundaries of HPR III, which includes Danville and Pittsylvania, Franklin, Henry and Patrick counties, and the City of Martinsville.

5. DRMC is a full-service, not-for-profit, acute-care hospital with 350 licensed beds. The Hospital is the third largest hospital in HPR III. DRMC is the primary inpatient provider for Danville and Pittsylvania County, as well as for Caswell County in North Carolina. The Hospital also serves as a referral center for all of PD 12, offering a full range of services, including many specialty and subspecialty services.

6. Sections 32.1-102.1 and 32.1-102.3 of the Code of Virginia require that "[a]n increase in the total number of . . . operating rooms [ORs] in an existing medical facility" and that "[a]ny capital expenditure of five million dollars or more, not defined as reviewable . . . [elsewhere in this section], by or in behalf of a medical care facility" must be approved by the State Health Commissioner through issuance of a COPN.

7. Virginia regulation, *viz.*, Chapter 270 of the State Medical Facilities Plan (SMFP) 12 VAC 5-270-10 *et seq*., contains standards and provisions with which the Commissioner may review applications for the addition of surgical services, or operating rooms.

8. In September 1999, the State Board of Health adopted emergency regulations specifically required by Virginia law enacted that year, *viz.*, Senate Bill 1282, and House Bills 2369 and 2543. Among other things, these bills required the Board of Health to adopt regulations "establish[ing] specific criteria for determining need in rural areas, giving due consideration to distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care in such areas. . . ." Under Section 2.2-4011 of the Virginia Code, emergency regulations may remain effective for a maximum of twelve months. The Board's 1999 emergency regulations, effective from January 3, 2000, to January 2, 2001, sought to amend the regulations governing the process by which the Department of Health reviews applications for COPNs and to amend the SMFP. Among other things, the Board sought to implement an amendment of 12 VAC 5-230-270 A, which addresses the need for operating room capacity. In that section, the Board's emergency regulation codified the consideration of

> the addition of operating rooms by existing medical care facilities in planning districts with an excess supply of operating rooms . . . when such addition can be justified on the basis of *facility-specific utilization*, geographic remoteness or both . . . . [Emphasis added.]

9. Although the emergency regulation containing the provision noted directly above was not in effect when DRMC submitted its application seeking additional operating rooms in PD 12, statutory law clearly provides an authorizing basis on which public need in rural areas and institutional need may be legitimately considered in reviewing applications for COPNs. Further, the institutional need provision was adopted as an emergency regulations in order to codify the existing policy of the Commissioner that facility-specific need is a relevant consideration in making a determination of public need. To illustrate, at least three of the Commissioner's decisions to issue COPNs approving additional ORs in HPR V made since 1998 have relied, in part, on the existence of institutional need. Notably, the Board of Health has begun and is continuing to carry out the regulatory process, prescribed by the Administrative Process Act, Virginia Code Section 2.2-4000 *et seq*., necessary to make permanent the provisions of the 1999 emergency regulations.

10. DRMC has experienced high demand for surgical services and appears to have an identifiable institutional need for additional operating capacity, as discussed in greater detail below in relation to 12 VAC 5-270-40. The utilization of DMC's nine ORs have exceeded the 1,600-hours-per-year-per OR standard since 1998. DMC expects its nine general purpose ORs to operate at over 123 percent of the 1,600-hour standard in 2001, and at nearly 151 percent of the standard in 2003.

11. As the following table shows, in recent years, DRMC has approached the median level of charity care for hospitals in HPR III, expressed as a percentage of a hospital's total gross patient revenue.

Charity Care Percentage of Gross Patient Revenue in Health Planning Region III, 1997, 1998 and 1999 (At 100 Percent of the Federal Poverty Level)

Facility	1997	1998	1999
Carilion Bedford County Memorial Hospital	2.0	3.0	2.7
Carilion Medical Center	n/a	2.6	2.5
Carilion Giles Memorial Hospital	2.5	2.9	2.2
Twin County Regional Hospital	3.0	3.0	2.2
Carilion Franklin Memorial Hospital	3.2	2.5	2.1
Wythe County Community Hospital	3.2	2.3	2.0
Carilion New River Valley Medical Center	n/a	1.7	1.9
Wellmont Lonesome Pine Hospital	2.1	1.6	1.8
Smyth County Community Hospital	1.4	2.0	1.8
Johnston Memorial Hospital	2.0	1.7	1.8
Buchanan General Hospital	1.4	1.9	1.8
Tazewell Community Hospital	1.2	1.8	1.4
Centra Health	1.4	1.7	1.4
St. Mary's Hospital (Norton)	1.8	2.0	1.3
Memorial Hospital of Martinsville & Henry County	1.5	1.1	1.3
Danville Regional Medical Center (DRMC)	***1.0***	***1.6***	***1.3***
Norton Community Hospital	0.7	0.8	1.2
Clinch Valley Medical Center	0.6	0.9	1.2
Pulaski Community Hospital	1.0	1.4	1.1
Dickenson County Medical Center	0.7	0.9	1.1
Montgomery Regional Hospital	0.7	1.7	0.9
Russell County Medical Center	0.8	0.7	0.8
Alleghany Regional Hospital	1.0	1.1	0.8
Lewis-Gale Medical Center	0.6	0.4	0.3
Lee County Community Hospital	2.3	0.6	0.0
Wise Appalachian Regional Hospital	1.3	1.1	n/a
Patrick Community Hospital	0.3	0.2	n/a
Carilion Roanoke Memorial Hospital	3.0	n/a	n/a
Carilion Roanoke Community Hospital	2.8	n/a	n/a
Carilion Radford Community Hospital	2.1	n/a	n/a
HPR Median	***1.4***	***1.7***	***1.4***

12. The HPASWV has recommended approval of the application. No person has come forward to lodge opposition to the application. By letter dated November 19, 2001, the Virginia Department of Health, Division of Certificate of Public Need (DCOPN) notified DMC that DCOPN recommends denial of the application.

13. An IFFC was convened on December 4, 2001, in Richmond pursuant to Sections 2.2-4019 and 32.1-201.6 of the Virginia Code to discuss this application. DRMC was represented by counsel at the IFFC.

B. DISCUSSION

Section 32.1-102.3 B of the Code of Virginia requires that, in determining whether a public need for a proposed project has been demonstrated, the State Health Commissioner shall review an application for a certificate of public need in relation to the twenty considerations enumerated in that section. The following is a discussion of the application in relation to these considerations.

The total capital cost of the entire proposed project, as presented and reviewed by HPASWV and DCOPN, is $5,954,100. The total capital cost relating only to construction of the proposed ORs is $3,959,200. Insofar as the capital expenditure aspect of the proposed project, if considered independent of the cost of the addition of the three proposed ORs, would be $1,994,900 – well under the five million dollar threshold for a capital expenditure to be reviewable under the COPN law when not otherwise reviewable substantively, DRMC's application is reviewable only the extent that it proposes to add ORs, or surgical capacity. The application will not be reviewed below to the extent that it proposes to implement a capital project that fails to meet the threshold amount, as a fair reading of the law appears not to authorize such review.

1. The recommendation and the reasons therefor of the appropriate regional health planning agency.

The Board of HPASWV has recommended approval of this project. The Board's vote was unanimous, with 20 in favor, one "registered conflict," and one abstention. The Board cited the following considerations in support of its recommendation:

(i) The project offers substantial improvements in efficiencies and access to care;

(ii) Charity care levels at DRMC are above average;

(iii) The costs of the project are reasonable and the project is financially viable;

(iv) The project fits with DRMC's strategic and development plans;

(v) DRMC's facility-specific needs indicate that the proposed ORs are needed to meet current demand; and

(vi) DRMC is a referral center for many specialty and subspecialty services; without this expansion, development of those services would be in jeopardy.

2. The relationship of the project to the applicable health plans of the regional health planning agency, the Virginia Health Planning Board and the Board of Health.

The applicable health plan is Part II of Chapter 270 of the State Medical Facilities Plan (SMFP), found at 12 VAC 5-270-10 *et seq*. (Text appearing under this consideration in italics has

been selected from the SMFP and precedes discussion of the proposed project in relation to the selected text.)

12 VAC 5-270-20. Acceptability. Self-referral. Surgical services providers should comply with all applicable federal and state statutes governing the ability of physicians to refer patients to facilities in which they have an ownership interest.

DRMC is a non-profit corporation and does not have any physicians with an ownership interest in the facility. DRMC's proposed project is consistent with this standard.

12 VAC 5-270-30. Accessibility; travel time; financial. Surgical services should be available within a maximum driving time, under normal conditions, of 45 minutes for 90 percent of the population.

Existing surgical services are situated so as to allow, under normal driving conditions, compliance with this standard. HPASWV recommends approval of this project, however, based in part on its finding that "DRMC has shown that often there is a substantial waiting period for elective cases; the practical effect is a lack of sufficient availability to meet the standard 100 percent of the time." DRMC asserts that

> [t]he undisputed evidence conclusively demonstrates that the ORs at DRMC are heavily utilized. Indeed, the utilization is so high that DRMC is experiencing significant difficulties in OR operations, including: (i) delays in getting surgical cases scheduled; (ii) cases being "bumped" to accommodate emergency surgeries; (iii) surgery performed late into the evening; [and] (iv) patients traveling to North Carolina for elective surgery due to delays in getting their cases scheduled. The extremely high utilization of DRMC's ORs means that its surgical services are often not accessible to the population. . . . ORs at Patrick Community Hospital in Stuart, Virginia and Carilion Franklin Memorial in Rocky Mount, Virginia are located more than one hour away from the DRMC population under normal driving conditions. . . .
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> [Further w]hile the SMFP . . . [accessibility standard] suggests that there are sufficient ORs to meet the PD 12 need, the formula fails to recognize important factors, such as the drive time limits on accessibility, limits on the ability of supposedly under-utilized ORs to handle complex surgery, and the bankruptcy and subsequent reduction in services at Patrick Community Hospital. With the addition of three new, state-of-the-art operating rooms and the replacement of one older, smaller operating room, DRMC will be able to reduce the delay . . . . A central objective of this proposed project is to improve geographically accessible surgical services to the residents of the communities served by DRMC.

Surgical services should be accessible to all patients in need of services without regard to their ability to pay or the payment source.

As shown in the table below, charity care provided by DRMC, represented as a percentage of total gross patient revenues, has approached, without exceeding, the median for HPR III for two of the last three years for which complete data exist.

Charity Care Provided by DRMC Compared to the HPR III Median

	1997	1998	1999
	1.0	1.6	1.3
HPR Median	1.4	1.7	1.4

Notably, DRMC points out that it "facilitate[s] the transport of patients residing in rural area [and] budgets approximately $80,000 annually to assist families and patients in need with travel expenses" involved in obtaining medical care. The mechanism for capturing a hospital's level of charity care, however, does not allow inclusion of such funding.

12 VAC 5-270-40. Availability; need. A. Need. The combined number of inpatient and ambulatory surgical operating rooms needed in a planning district will be determined . . . [according to the computational methodology set forth in this provision, which includes factors such as (i) recent operating room utilization, (ii) recent and projected population, and (iii) the average length of operating room visits].

No additional operating rooms should be authorized for a planning district if the number of existing or authorized operating rooms in the planning district is greater than the need for operating rooms identified using . . . [this] methodology. New operating rooms may be authorized for a planning district up to the net need identified by subtracting the number of existing or authorized operating rooms in the planning district from the future operating rooms needed in the planning district, as identified using the [methodology set forth in this subsection].

Like many provisions of the SMFP, this one seeks to ensure that ORs in a PD are optimally utilized and that facilities do not undertake capital investments which would not be used efficiently in serving public need for surgical services.

Currently, a total of 19 ORs serve PD 12. HPASWV notes that the data upon which this review must rest are unreliable, due in part to alleged incomplete reporting. Consistent with this observation, DRMC concluded in its July 2001 application that PD 12 will have a surplus of five ORs in 2003, while, at the IFFC, DRMC's counsel represented that a more conservative estimation would involve a surplus of one OR. Using the methodology set out in the SMFP, DCOPN estimated that PD 12 will need 21 ORs in 2003 and will, therefore, have a deficit of two ORs.

Regardless of whether a deficit or a surplus of ORs will exist in PD 12, the institutional need of DRMC – the busiest hospital in a predominantly rural area – may justify an approval of the proposed project to add three ORs at that hospital. Several recent approvals of applications for COPNs recognize that, despite the existence of a surplus within a particular PD, an individual facility's institutional need may justify expansion of OR capacity. These decisions reflect the reality that excess capacity in a PD does not adequately compensate for need experienced at a particularly well-utilized facility. Approval of DRMC's application would be consistent with these recent decisions, in which similarly-situated hospitals received authority for additional surgical capacity.

In the present matter, DRMC appears to have an identifiable institutional need for additional operating capacity. The utilization of DRMC's nine ORs have exceeded the 1,600-hours-per-year-per

OR standard since 1998. Based on annualized data, DMC expects its nine general purpose ORs to perform 17,770 surgical hours in 2001, which would equate to the use of over eleven general purpose ORs based on the 1,600-hour standard and to a utilization rate of over 123 percent. Further, DRMC projects its nine ORs will perform 21,697 surgical hours in 2003, which would equate to the use of over 13.5 ORs and to a utilization rate of nearly 151 percent of the standard. In light of these projections, DRMC's application for three additional ORs, which would bring the hospital's total complement to 12 ORs, appears somewhat conservative.

12 VAC 5-270-50. Cost; charges. [This provision allows the creation of a preference among competing applications for surgical services and is not applicable.]

12 VAC5-270-60. Quality; accreditation/licensure. A. Surgical services providers should meet all applicable accreditation standards of the Joint Commission on the Accreditation of Healthcare Organizations or the Association for Accreditation of Ambulatory Health Centers and licensure standards of the Department of Health.

DRMC maintains accreditation through the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and appears to comply with applicable licensure standards of the Department of Health.

B. Existing and proposed providers of surgical services should document the availability of physicians who are board-certified or board-eligible in appropriate surgical specialties.

DRMC currently has on staff physicians who are board-certified or board-eligible in all general surgical specialties and subspecialties.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

DRMC represents that it developed a system-wide, general strategic plan in 1996. In implementing this plan and a community need assessment, DRMC "has determined that additional ORs is a critical need."

4. The need that the population served or to be served by the project has for the project, including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

For general acute care services, DRMC's historical primary service area has included the City of Danville and Pittsylvania County in Virginia and Caswell County in North Carolina. DRMC's secondary service area for general acute care services has included the City of Martinsville and Henry and Halifax counties in Virginia, as well as Person and Rockingham counties in North Carolina. DRMC's surgical data regarding patient origin for 1999 and 2000 indicate that 90 percent of the surgical volume performed at DRMC in 2000 originated within the primary service area, and 59 percent of that volume involved patients residing in Danville.

As discussed above, DRMC has experienced high utilization of its surgical services. Utilization for the current year is expected to exceed 123 percent. Some migration of the area's residents to facilities in North Carolina for surgical services reportedly occurs because ORs at DRMC are not available when needed; DRMC's proposed project would meet the needs of its patient population by providing greater and more efficient access to surgical services.

Based on data from the 1990 U.S. census, the total Virginia population of DRMC's service area is 63 percent rural and 37 percent urban. DRMC is the primary referral center for PD 12 and provides the most sub-specialty hospital care for its citizens. Recently, the Commissioner approved open-heart surgical services at DRMC, to be provided in collaboration with Duke University. Expanding the OR capacity at DRMC would provide the rural population of the service area, as well as the urban populations of Danville and Martinsville, with better access to surgical services.

The General Assembly amended Virginia Code Section 32.1-102.3 B in 1999 to include the latter phrasing in the fourth statutory consideration, set out above, directing special attention to "the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care" (as well as similar phrasing in the sixth, ninth and nineteenth statutory considerations, below). *See* Acts of Assembly, c. 926, 1999. In light of the potential of the proposed project to enhance availability of surgical services to residents of a predominantly rural service area, the project may be seen as the type of application to be afforded careful attention under this consideration, as amended in the wisdom of the General Assembly.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

DRMC is accessible to residents of the area proposed to be served via urban streets in Danville and State Route 86. DRMC has sufficient parking with a covered drive-up area for patient ingress. City bus routes serve the hospital premises. Cab service is available in the City of Danville. DRMC meets accessibility requirements imposed by the Americans with Disabilities Act of 1990.

Charity care provided by DRMC, represented as a percentage of total gross patient revenues, has approached, without exceeding, the median for HPR III for two of the last three years for which complete data exist.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health service area in which the project is proposed, in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

DRMC serves as a referral center for all of Planning District 12, which includes the cities of Danville and Martinsville and the counties of Pittsylvania, Franklin, Henry and Patrick, as well as adjacent counties in North Carolina, offering a wide array of specialty services. The population of Planning District 12 is approximately 250,000. Portions of the service area are mountainous and occasionally impassable due to inclement weather. Three U.S. highways serve the City of Danville: U.S. Highway 29, which runs north and south, and U.S. Highways 58 and 360 that run east and west. All three highways pass within two miles of DRMC's campus and are linked to it by urban streets.

Amtrak provides train service to Danville, and Trailways and Greyhound provide inter-city bus service.

No other provider in PD 12 provides equivalent levels of specialty and sub-specialty care. DRMC's proposed project will improve geographic access to surgical services by giving DRMC the ability to meet the demand for surgical services in the area, thereby eliminating the need for residents to travel to North Carolina and elsewhere for surgical care.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

While maintaining the status quo would be less costly, it would not be effective because the access problems created by DRMC's over-utilization would remain. No less costly or more effective alternative means of meeting the surgical needs of the service area appear to exist. Patrick Community Hospital and Carilion Franklin Memorial Hospitals cannot handle the complex surgical cases performed at DRMC. DRMC's surgeons are not on the medical staff at those hospitals, and it is impractical for them to be. Without approval of the proposed addition of ORs at DRMC, some patients may be forced to find new surgeons, resulting in significant disruption of care and increased expense.

8. The immediate and long-term financial feasibility of the project.

DRMC has total assets of over $154 million, and cash equivalent assets of over $21 million. The proposed project would be funded from accumulated cash reserves, so no debt service cost would accrue. DRMC has demonstrated positive cash flow for several years and forecasts this trend to continue. DRMC has the necessary financial resources to implement, complete and capitalize on this project. The project would be financially feasible over the immediate and long term.

9. The relationship of the project to the existing health care system of the area in which the project is proposed; however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.

As noted above, DRMC is a full-service, not-for-profit, acute care hospital, licensed for 350 beds. It is the third largest hospital in Health Planning Region III. Although DRMC is one of four hospitals in PD 12, it has the capability to provide more complex surgical procedures than those available at the community hospitals located in other counties. It serves as a referral center for all of Planning District 12 as well as adjacent counties in North Carolina.

10. The availability of resources for the project.

DRMC has adequate financial resources to plan, implement, and profit from this project. The total cost of the reviewable aspect of the proposed project, which is $3,959,200, would be paid from accumulated cash reserves. The human resources needed to make the project a success are also available. DRMC's current programs, modernized facilities and cooperative arrangement with Duke University's open-heart surgery program should help enable DRMC to meet any need to recruit physicians and support personnel. DRMC operates a nursing school for registered nurses and supports the licensed practical nursing program of Danville Community College, providing promising sources of nursing staff.

11. The organizational relationship of the project to necessary ancillary and support services.

DRMC is a licensed general acute care hospital, certified by JCAHO. Necessary ancillary services for support of the proposed addition of ORs are in place.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

As noted above, DRMC operates a nursing school for registered nurses and supports the licensed practical nursing program of Danville Community College. The proposed expansion of surgical capacity should provide additional opportunities for nursing education and technical training through the continued operation of these programs.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.

Not applicable.

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.

DRMC accepts all patients covered by health maintenance organizations (HMOs) operating in southwest Virginia. Because DRMC currently provides surgical services and proposes to expand those services, has adequate operating revenue and a demonstrated need to increase the capacity, HMO enrollees should derive benefits of access without facing increased costs and charges.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

Not applicable.

16. In the case of a construction project, the costs and benefits of the proposed construction.

The construction costs relating to the proposed project are considerable but generally reasonable and the architectural drawings promise enhanced workflow and circulation patterns for patients and staff and rationalization of programmatic activities. The overall benefit of increased

access to advanced surgical services for patients in the area would likely outweigh the monetary outlay that is necessary for the expansion.

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

DRMC estimates that costs per adjusted patient day will increase by three percent per year, which is less than the annual increase in healthcare of approximately eight percent that has prevailed over the last decade.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

Not applicable.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

Other facilities in PD 12 provide general surgical services that are under utilized. These facilities provide less complex surgical services within rural communities, and often make referrals to DRMC as well as to Duke University and the University of Virginia Medical Centers. It is unlikely that existing surgical services in HPR III can meet the needs of DRMC's service area. The geographic distances that prevail and the desire of many patients to be treated within their community would likely be an obstacle to referral.

20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

Not applicable.

C. RECOMMENDATION

I have reviewed the application and subsequent submissions of Danville Regional Medical Center (DRMC), seeking three additional operating rooms (ORs). I have heard from counsel to DRMC in support of the application and from the staff of the Division of Certificate of Public Need (DCOPN) who evaluated the proposal. I have considered the recommendation of the board of directors of the Health Planning Agency of Southwest Virginia (HPASWV) which recommended approval of the application.

Based on my assessment, I have concluded that the proposal merits approval and should receive a certificate of public need (COPN), subject to the following condition, as authorized by Virginia Code Section 32.1-102.2 C, *viz.*:

That DRMC will provide general surgical services to all patients without regard to ability to pay. This obligation may be implemented by (i) providing free services to persons at or below 100 percent of the federal poverty level who have no third-party health care coverage, by (ii) providing free or reduced-charge services to persons above 100 percent of the federal poverty level and at or below 200 percent of the federal poverty level who have no third party health care coverage, or by (iii) a combination of these two approaches. DRMC will also make good faith, reasonable efforts to encourage similarly-beneficial consideration of patients' financial circumstance by associated physicians and medical services.

The specific reasons for my recommendation include:

(i) The proposed project is substantially compliant with most applicable standards and provisions of the State Medical Facilities Plan (SMFP);

(ii) The board of directors of the HPASWV voted overwhelmingly to recommend approval of the proposed project;

(iii) Although a surplus of operating rooms (ORs) in Planning District (PD) 12 may exist, the ORs at DRMC are experiencing a utilization rate greater than the applicable standard, demonstrating an institutional need for additional surgical capacity at that facility;

(iv) The COPN program was never intended and is not designed to impede successful facilities in their efforts to care effectively for current and anticipated patients;

(v) Specific conditions relating to the rural nature of DRMC's service area and the population's need warrant additional surgical capacity at DRMC – a referral center for PD 12;

(vi) The proposed project offers substantial improvements in efficiencies and access to care for the intended population, which is overwhelmingly rural; and

(vi) The costs and projected charges relating to the project proposed by DRMC are generally reasonable, and no less costly and more effective alternative to the addition of ORs to that hospital's surgical suite appears to exist.

Respectfully submitted,

Douglas R. Harris, J.D.
Adjudication Officer